Hawaii Dept. of Health, Office of Health Care Assurance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125019 | A. BUILDING: _____ B. WING _____ | 09/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE CARE CENTER OF HONOLULU | 1900 BACHELOT STREET HONOLULU, HI 96817 |

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| 4 000 | Initial Comments<br><br>A re-licensure survey was conducted by the Office of Health Care Assurance (OHCA) on 09/09/20 to 09/14/20. The facility reported census was 161 residents at time of entrance. | 4 000 | | |
| 4 099 | 11-94.1-22(a) Medical record system<br><br>(a) The facility shall have available sufficient appropriately qualified staff and necessary supporting personnel to facilitate the accurate processing, auditing and analysis, indexing, filing, and prompt retrieval of records, record data, and resident health information.<br><br>This Statute is not met as evidenced by:<br>Based on observation, record review and staff interview, the facility failed to ensure the communication process with hospice and long term care services included timely and accurate clinical documentation for one of 32 residents Residents (R) 96 in the final sample. This deficient practice has the potential to affect all hospice residents residing in the facility.<br><br>Findings Include:<br><br>R96 was admitted to hospice care services on 07/25/90 with a terminal diagnosis of chronic lymphocytic leukemia B-cell without remission, and a life expectancy of six months or less. R96 was able to slowly verbalize her needs such as where to put the pain patch on her during a medication pass observation.<br><br>Review of the hospice clinical records found R96's 07/25/20 start of care (SOC) record had orders for skilled nursing (SN) services, which included SN visits twice a week for 12 weeks | 4 099 | 4099<br>Hospice Records<br><br>1) All residents on Hospice services have the potential to be affected by this process.<br><br>2) The Hospice company has been contacted and the visit notes prepared by the Hospice company for Resident R96 have been added to our facility records.<br><br>3) The Director of Nursing and / or designee will educate the licensed nursing staff and Medical Records team on the tracking and collection of Hospice records for inclusion in the residents electronic medical record at the facility in a timely fashion.<br><br>4) The Director of Nursing and / or designee will perform weekly audits for 4 weeks or on an ongoing basis until | 10/23/20 |

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/25/20

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| 4 099 | Continued From page 1<br>from 08/02/2020 to 10/22/2020. The sign-in sheet showed the hospice registered nurse (RN) assigned to R96's care came on 08/03, 08/05, 08/10, 08/17, 09/02/20. The last SN note by the hospice RN was 08/10/20.<br><br>On 9/11/20 at 12:59 PM, UM1 was asked about the missing SN visit notes by the hospice RN as they were not found in the clinical record. UM1 was also informed the hospice RN's signatures were missing on the sign-in sheet to correlate whether the hospice RN was coming to see R96 according to the physician ordered SN visits/frequency.<br><br>The UM1 said another nurse came to see R96, "before lunch just today (9/11/20) because I think (the assigned hospice RN) is on vacation." She said the hospice RN also came on 9/8/20 too, but acknowledged their clinical documentation was missing. UM1 affirmed there currently was no note and the hospice RN failed to sign the sign-in sheet for several visits. UM1 said she would follow-up with this hospice to have the documentation sent over. UM1 acknowledged it was hard to track and without up-to-date documentation by hospice of the resident's status, they too, would not clearly know what the resident's condition could be. UM1 acknowledged this would be the case if a family member called and had no hospice note/assessments in the record to report by.<br><br>On 09/14/20 at 10:58 AM, another interview with UM1 was done. She said, "it's actually hard to track who comes and who they coming to see. At this time, I believe I'm not tracking when they come, because I don't know their schedule. It's not only one hospice, but different hospices." UM1 said, "It's a plan of correction because I | 4 099 | substantial compliance is achieved. Areas of concern will be addressed immediately. Findings will be reported to the QAPI Committee.<br><br>5) The QAPI Committee will review the findings presented to the Committee to verify substantial compliance has been achieved. If the audits reveal that the Plan of Correction goal has not been achieved, then the Administrator will adjust the Plan of Correction until substantial compliance is met using the QAPI process. | |

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| 4 099 | Continued From page 2<br>myself don't know when they're coming in." UM1 said the hospice provider could not access their electronic medical record system so she would have to ask the various hospices to send over their clinical notes.<br><br>For R96, UM1 acknowledged the hospice provider was responsible to maintain up-to-date clinical notes in R96's clinical record. After obtaining the faxed hospice notes, it showed SN visits were done on 08/12, 08/16, 08/19, 08/24 and 09/11/20. However, there was no 09/09/20 SN nursing note, which UM1 confirmed.<br><br>Thus, there was missing documentation/ communication by the hospice staff as found in R96's clinical record, with the first faxed set of hospice notes still being incomplete. In addition, the hospice RN's visits failed to meet the physician ordered frequency of visits for the stated certification period. | 4 099 | | |
| 4 125 | 11-94.1-27(14) Resident rights and facility practices<br><br>Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including:<br><br>(14) The right to personal privacy and confidentiality of personal and clinical records;<br><br>This Statute is not met as evidenced by:<br>Based on observation and staff interview, the | 4 125 | 4125 | 10/23/20 |

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| 4 125 | Continued From page 3<br>facility failed to ensure residents were provided personal privacy during 1) personal care for one of 32 residents Resident (R) 356 in the initial pool sample, and 2) failed to provide confidentiality of a resident's status during a staff's telecommunication meeting. These deficient practices have the potential to affect all residents residing in the facility.<br><br>Findings Include:<br><br>1) On 09/09/20 at 12:53 PM, from the unit 3 hallway, surveyor observed R356's lower legs uncovered while he lay in bed. His privacy curtains were not drawn and R356 was saying something. Surveyor donned a new disposable gown and went to see R356. The resident mumbled something about his knees, "going to give out." At that time, his left leg went off the bed and dangled to the left side where his Foley catheter bag was. R356's lay there with his brief fully exposed and his hospital gown bunched up above his stomach and around his chest. R356's roommate was able to see R356 in full view like this.<br><br>A registered nurse (RN) 24 then came into the room after donning a disposable gown. R356 repeated his knee concern, but RN24 did not notice he was exposed to public view and went to the task of lifting R356's leg back onto the bed. When RN24 was asked about providing privacy for him since most of his body was exposed, RN24 then nodded, and said, "Oh yes, privacy," and then pulled the privacy curtains around him.<br><br>2) On 09/14/20 at 10:58 AM, during a hospice record review with the unit manager (UM)1 at the nurse's station, RN24 was seen walking in the unit 3 hallway holding an ipad like device while | 4 125 | Dignity / Confidentiality of Records<br><br>1) These practices have the potential to affect all residents residing in the facility.<br><br>2) All direct care staff will be educated on maintaining the dignity of all residents using privacy curtains while providing care. Additionally, all interdisciplinary team and license nurses will be educated on the confidentiality of resident□s personal information during telecommunication meetings.<br><br>3) The Director of Nursing and / or designee will perform care observations audits to evaluate compliance with personally privacy / confidentiality of residents□ records 2 times weekly for 4 weeks or on an ongoing basis until substantial compliance is achieved. Areas of concern will be addressed immediately. Findings will be reported to the QAPI Committee.<br><br>4) The QAPI Committee will review the findings presented to the Committee to verify substantial compliance has been achieved. If the audits reveal that the Plan of Correction goal has not been achieved, then the Administrator will adjust the Plan of Correction until substantial compliance is met using the QAPI process. | |

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| 4 125 | Continued From page 4<br>speaking loudly to someone about a resident's status. Surveyor asked UM1 whom RN24 was speaking to since she could be overheard talking loudly about a resident. UM1 affirmed RN24 was loud and said RN24 was speaking to an outside provider about a resident. RN24 could be heard from the hallway, in the presence of other residents and staff.<br><br>UM1 stood up to have RN24 go to the back of the nurse's station. However, RN24 kept talking loudly without lowering her voice or pausing, while holding the ipad like device and being directed to the back room. There was a breach in how a resident's personal information was being openly discussed by RN24, which continued even after she was directed by UM1 to move to the back. | 4 125 | | |
| 4 243 | 11-94.1-64(a) Engineering and maintenance<br><br>(a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition.<br><br>This Statute is not met as evidenced by:<br>Based on observation, staff interview, record review, and review of equipment service manual, the facility failed to ensure routine maintenance, based on the manufacturer's recommendation, for one out of three oxygen concentrators reviewed. This deficient practice put Resident (R) 45 at risk for the development and transmission of communicable diseases and infections.<br><br>Findings Include:<br><br>During an observation, on 09/09/2020 at 11:38 AM, of R45's room, a Perfecto2 V Oxygen Concentrator was noted at bedside. The inlet | 4 243 | 4243<br>Essential Equipment<br><br>1) All residents using an air concentrator are at risk of this process. The air filter for Resident R45 was removed and cleaned immediately. All other air concentrator filters were removed and cleaned.<br><br>2) The Asst Administrator and/or designee will educate the housekeeping staff on the weekly routine cleaning of air concentrator filters and weekly cleaning schedule check list. | 10/23/20 |

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| 4 243 | Continued From page 5<br>filter of that oxygen concentrator appeared to have dirt and/or dust on the inlet filter.<br><br>A review of R45 Electronic Health Record (EHR) showed that R45 was admitted on 11/26/19 with a diagnoses of Quadriplegia, Diabetes, Anemia, Major Depressive Disorder, Cystostomy, Neuromuscular dysfunction of Bladder, Autonomic Dysreflexia, Hypertension, Dysphagia. R45 had a doctor's order to use oxygen for respiratory distress.<br><br>On 09/11/2020 at 02:39 PM, Respiratory Therapy Aide (RT) 1 was interviewed and stated that RT Staff was responsible for the preventive maintenance of oxygen concentrators and that a doctor's order to perform the preventive maintenance, such as cleaning the inlet filter, should be added for any patient using an oxygen concentrator.<br><br>Upon further review of the EHR for R45, there was an order for oxygen but there was no order to perform preventive maintenance, cleaning the inlet filter for the oxygen concentrator being used.<br><br>A review of the Service manual for the Perfecto2 V Oxygen Concentrator, Section 6 - Preventive Maintenance revealed the following: Cleaning the cabinet filter. There is one cabinet filter located on the back of the cabinet. 1. Remove the filter and clean at least once a week depending on environmental conditions. Note: Environmental conditions that may require more frequent cleaning of the filters include but are not limited to; high dust, air pollutants, etc. 2. Clean the cabinet filter with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. 3. Dry the filter thoroughly before reinstallation. As previously mentioned, the facility failed to ensure | 4 243 | 3) The Asst Administrator and / or designee will monitor the weekly cleaning of air filters for air concentrators for 4 weeks or on an ongoing basis until substantial compliance is achieved. Areas of concern will be addressed immediately. Findings will be reported to the QAPI Committee.<br><br>4) The QAPI Committee will review the findings presented to the Committee to verify substantial compliance has been achieved. If the audits reveal that the Plan of Correction goal has not been achieved, then the Administrator will adjust the Plan of Correction until substantial compliance is met using the QAPI process. | |

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| 4 243 | Continued From page 6<br>routine maintenance, based on the manufacturer's recommendation, was done for this resident. | 4 243 | | |